

UNITED STATES DISTRICT COURT  
NORTHERN DISTRICT OF NEW YORK

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PAUL MURPHY, Regional Director of Region 3 of the  
National Labor Relations Board, for and on behalf of the  
NATIONAL LABOR RELATIONS BOARD

Case No.: 3:17-MC-0004

-Against-

CAYUGA MEDICAL CENTER

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**MEMORANDUM OF LAW IN OPPOSITION TO PETITION FOR TEMPORARY  
INJUNCTION UNDER SECTION 10(J) OF THE NATIONAL LABOR RELATIONS  
ACT**

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### **PRELIMINARY STATEMENT**

This Memorandum of Law is submitted on behalf of Respondent, Cayuga Medical Center (“Respondent” or “CMC”) in response to Region Three of the National Labor Relation Board’s (“Region Three” or “Petitioner”) Petition for Injunctive Relief Under Section 10(j) of the National Labor Relations Act (“NLRA” or “Act”), As Amended (“Injunction Petition”)

Region Three’s Injunction Petition seeks the interim reinstatement of two Intensive Care Unit (“ICU”) nurses, Anne Marshall and Loran Lamb. As set forth in detail below, the two nurses knowingly and deliberately ignored the final critical step in CMC’s blood transfusion process (performing a two-person bedside verification inside the room) and falsified records to cover up this violation. Indeed, Ms. Lamb indicated she had performed the final bedside check despite admittedly never setting foot in the patient’s room. In addition, when the nervous transfusion patient asked Ms. Marshall why the transfusion process was being performed differently than all other transfusions she had received at CMC, Ms. Marshall lied and stated, in sum and substance, “that’s not how we do it here.” Ms. Marshall further unnerved the patient by telling her that the previous CMC nurses must have been inexperienced. After receiving the patient’s complaint, CMC conducted a thorough multi-layered investigation that resulted in Ms. Marshall and Ms. Lamb’s termination.

The New York State Education Department (“NYSED”), Office of the Professions, the entity responsible for the licensing and discipline of nurses in New York, performed their own independent investigation of the incident. On February 17, 2017, the Regional Office of the NYSED completed its investigation, finding “sufficient evidence” of professional misconduct to warrant prosecution. This prosecution may result in the suspension or revocation of Ms. Marshall’s and Ms. Lamb’s licenses.

By requesting immediate reinstatement, Region Three's petition is asking CMC and this Court to ignore the following:

- (1) Ms. Marshall and Ms. Lamb knowingly and deliberately violated the most fundamental and critical step in CMC's blood transfusion process;
- (2) Ms. Marshall and Ms. Lamb falsified medical records to cover up this violation;
- (3) Ms. Lamb certified she had performed a final check despite the fact that she had never entered the patient's room;
- (4) Ms. Marshall lied to the concerned patient about CMC's policy and caused further concern by telling the patient her other nurses must have been inexperienced;
- (5) Ms. Marshall insisted she doesn't need to follow CMC blood transfusion policy because she has the ability to multitask;
- (6) The NYSED investigation found sufficient evidence of professional misconduct;
- (7) Dr. Sudilovsky, the CMC Laboratory Director under whose license all blood transfusions must be administered, would refuse to allow these nurses to perform transfusions under his license; and
- (8) Reinstatement would undermine CMC's ability to enforce other necessary and potentially life-saving policies.

By asking this Court to reinstate these two employees, Region Three ignores the real potential harm to CMC patients. Region Three asserts the nurses must be reinstated because (1) there is no longer a union organizer at CMC and (2) employees may be intimidated from showing support for the Union. Putting aside the misguided notion that places collective bargaining rights over the risk to human life, the evidence does not support Region Three's claims that organizing activity has been negatively impacted by the nurses' terminations.

Under these circumstances, Region Three has not met its burden under the applicable tests, particularly because reinstatement could endanger the health and safety of the public. Accordingly, Region Three's request for injunctive relief should be denied.

### **STATEMENT OF FACTS**

Both Anne Marshall and Loran Lamb were suspended pending investigation into a patient complaint and subsequently given the opportunity to resign in lieu of discharge for admittedly and deliberately committing patient safety violations and falsifying medical records.

#### **A. The Blood Product Administration Policy**

Blood transfusions are a high-risk critical procedure that could have a lethal outcome if an error results in transfusion of the wrong blood type. (Declaration of Karen Ames ("Ames Decl."), at ¶ 10); Declaration of Dr. Daniel Sudilovsky ("Sudilovsky Decl."), at ¶ 3).

Accordingly, CMC maintains a Blood Product Administration Policy to ensure that transfusion patients receive the proper blood. (Ames Decl., at ¶ 10, Ex. F). As relevant to the facts of this case, the Blood Product Administration Policy states:

#### **Transfusion of Packed Cells or Whole Blood**

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12. A two-tier verification should be implemented on inpatient floors:

- A. Before taking blood into the patient room, the two nurses must verify the blood against the order and chart for correct patient name, blood type, type of blood product. No product should enter the patient room until it is verified.
- B. Inside the room, verification must occur matching the blood to the patient with two identifiers (name, date of birth [DOB]); verbally and against the patient wrist band.
- C. The blood must not be hung before the verification has occurred. If the nurse is interrupted for something more pressing, the incoming nurse will need to re-verify that the product is correct before transfusing.

13. Perform the 2-RN bedside checklist:
  - A. Verify the provider's order.
  - B. Verify that the consent has been signed by the patient (or appropriate representative).
  - C. Check the blood bag number, expiration date, blood type and Rh.
  - D. Two RNs must identify the patient at the bedside by asking the patient his name or her name and date of birth. This is compared to the patient's armband and blood Transfusion Card.
  - E. Transfusion card will be completed in its entirety by two RNs/GNs and upon completion returned immediately to the lab.

(Ames Decl., Ex. F).

Accordingly, two separate verifications by two nurses must occur before the transfusion can begin. (Ames Decl., at ¶ 11). The first verification occurs before the blood can be brought into the room. (*Id.*). During this verification, the two nurses must examine the patient information as well as the information on the blood bag from the laboratory. (*Id.*). Both nurses must verify that everything matches, at which point the blood can be brought into the patient's room. (*Id.*). This outside-the-room verification requirement was added to the Blood Product Administration Policy in 2013 after a near-miss incident in October 2012 when a patient almost received the wrong blood. (*Id.*).

The second verification occurs once the blood is in the patient's room. (Ames Decl., at ¶ 12). Again, the two nurses must verify the patient's name and date of birth (which requires the nurses to check the patient's identification bracelet), and compare that information against the order and label on the bag. (*Id.*). At that point, the blood bag can be hung and the infusion commenced. (*Id.*).

This second verification has at all times been a part of CMC's Blood Product Administration Policy and is a national standard of care. (Ames Decl., at ¶ 12-14, Ex. G).

Indeed, this final two-person bedside verification process is absolutely fundamental as a final safeguard against a potentially fatal error prior to starting a blood transfusion. (Ames Decl., at ¶ 13; Sudilovsky Decl., at ¶ 4). In fact, it is the final bedside verification that saved the patient in October 2012 from receiving the wrong blood. (Ames Decl., at ¶ 14). It is the last line of defense before a patient receives blood and is imperative in ensuring patient safety. (*Id.*; Sudilovsky Decl., at ¶ 4).

Once a transfusion is complete, both nurses involved in the verification process are required to complete a Blood Transfusion Card in the medical record certifying that every step of the verification process was followed and that the transfusion was administered in accordance with all of the necessary safeguards. (Ames Decl., at ¶ 15). It is expected that the nursing staff accurately completes the Blood Transfusion Card, and falsification of that medical record, as with any other medical record, is grounds for discipline, including, termination. (*Id.*).

#### **B. Incident on September 11, 2016 and the Subsequent Investigation**

On September 11, 2016, Ms. Lamb and Ms. Marshall were assigned to perform a blood transfusion for a particular patient. (Ames Decl., at ¶ 4). This patient had regularly received blood transfusions prior to this date and was therefore familiar with the verification process. (Ames Decl., at ¶ 3). The patient made a complaint to Charge Nurse, RN Scott Goldsmith stating that the two nurses who performed the transfusion failed to properly verify both her ID and the blood to be used in the transfusion before starting the blood transfusion process. (Ames Decl., at ¶ 3, Ex. A). In fact, only one nurse was in the room at that time. (Ames Decl., at ¶ 3). Thereafter, Mr. Goldsmith entered the complaint into the incident reporting system. (Ames Decl., at ¶ 3). Following the receipt of the incident report completed by Mr. Goldsmith, Karen

Ames, Chief Patient Safety Officer & Director of Quality and Patient Safety, commenced an investigation into the September 11 incident. (Ames Decl., at ¶¶ 1,5).

On September 16, Ms. Ames and Deb Raupers, Director of Patient Services, interviewed the patient. During this interview, the patient indicated that: “in all other instances of hanging blood two nurses always came to bedside to conduct verification and patient ID. She noticed that this time only one nurse [Ms. Marshall] hung the blood carrying out these steps or checking her name band and wondered why [there was a] difference.” (Ames Decl., Ex. B; see also, Exs. C & D). The patient also told Ms. Ames and Ms. Raupers that she questioned the nurse at the time about the verification procedure and the nurse indicated that “she (and the other nurse) checked everything at the nurse station.” (Ames Decl., Ex. B at p. 3; see also, Exs. C & D). In addition to the information provided during the September 16 interview, on September 19 the patient submitted a written statement to Ms. Ames about the incident, which indicated that: “All previous nurses had made me aware of this protocol and led me through it – this nurse did none . . . I need the hospital to be aware of this breach [sic] of protocol and seriousness I felt being vulnerable in my bed.” (Ames Decl., ¶ 7; see also Ex. D).

Ms. Raupers and Ms. Ames then interviewed the patient’s sister, a critical care RN in Maine, who witnessed the September 11 incident. (Ames Decl., at ¶ 8). The patient’s sister reported that when asked “where is the 2nd nurse for the blood transfusion, [Ms. Marshall’s] reply [was] ‘We don’t have to do that,’ [and when] questioned why another nurse did, [Marshall’s] reply [was] ‘That must have been a new nurse.’” (*Id.*). The patient’s sister also stated that, “As an experienced critical care RN, I was shocked by the responses.” (*Id.*).

Ms. Ames reviewed the Blood Transfusion Card for the patient’s September 11 transfusion. It had been completed by both Ms. Lamb and Ms. Marshall. (Ames Decl., at ¶ 8).

In the box with the heading “Below information must be verified at Patient Bedside” both nurses provided their initials and signed the card certifying that the correct procedures had been followed, even though according to the patient’s and family member’s report, this was not the case. (*Id.*; see also, Ex. E).

Ms. Lamb was interviewed on September 21. (Ames Decl., at ¶ 16). During that interview, she admitted she never even entered the patient’s room for this transfusion. She said she made a mistake and said she was sorry. (*Id.*). Ms. Lamb went on to acknowledge that: (1) she understood the Blood Products Administration Policy; (2) she recently completed and understood the blood product training; and (3) that she knew that blood administration is a high-risk process and that an error could be fatal for the patient. (*Id.*). When asked about any contributing factors, Ms. Lamb said that the unit was busy at the time, but that this was no excuse for not completing the two-person check at the bedside. (*Id.*).

Given the information received from Ms. Lamb that the unit was busy at the time of the admitted policy breach, Ms. Ames reviewed the staffing records. (Ames Decl., at ¶ 19). Her review of those records showed that: (1) each ICU nurse had two patients, which is the normal ratio; (2) the charge nurse had no patient assignment and was readily available to assist as needed; and (3) there was an RN designated as on-call who could have been (but was not) called in. (*Id.*). Additionally, Ms. Ames followed-up with Mr. Goldsmith, the Charge Nurse on duty that day, and he confirmed staffing was at the normal ratio and there were no emergencies. ((Ames Decl., at ¶ 20); see also Ex. I).

Ms. Ames spoke with Ms. Marshall about the September 11 incident on October 4, following her return from a pre-scheduled vacation. (Ames Decl., at ¶ 21). Ms. Marshall admitted that she knew the policy but chose not to follow it because she was busy at the time.

(*Id.*). Seemingly unremorseful and unapologetic about her error, she argued that the verification policy is flawed. (*Id.*). Ms. Marshall diminished the importance of the verification process to patient safety by asserting that she is fully capable of doing the final verification outside the patient's room while multi-tasking. (*Id.*). This was particularly reckless since CMC policy declares blood product administration to be a "safety zone process", meaning that all steps must be performed from start to finish without interruption, and if an interruption does occur the process must be restarted at the beginning and carried through to completion without interruption. (*Id.*).

Based on the information learned during the investigation, CMC concluded that Ms. Marshall and Ms. Lamb: (1) knowingly and deliberately violated policy and committed a fundamental breach of patient safety that placed the patient in danger of a potential lethal outcome; (2) caused the vulnerable patient fear and distress because she was aware of the nurses' disregard of the necessary safety precautions; and (3) falsified the Blood Transfusion Card by certifying that the bedside verification had been performed. (Ames Decl., at ¶ 24; Raupers Decl., at ¶ 4). In addition, Ms. Marshall disregarded the patient's own concern about following the proper protocol, and Ms. Lamb failed to even enter the patient's room despite certifying that she had. (Ames Decl., at ¶ 24; Declaration of Deb Raupers ("Raupers Decl."), at ¶ 4).

### **C. The Decision to Terminate Loran Lamb and Anne Marshall**

As standard course, the September 11 incident was submitted to CMC's Nursing Peer Review Committee, which is comprised of 6-12 RNs from across different care areas at CMC. (Ames Decl., at ¶ 17). As standard practice, after reviewing all relevant information concerning the incident, each committee member rendered one of four possible judgments:

- 1 – Most experienced, competent practitioners would have managed the case in a similar manner
- 2 – Most experienced, competent practitioners might have managed the case differently
- 3 – Most experienced, competent practitioners would have managed the case differently
- 0 – Reviewer uncertain, needs committee discussion

(Ames Decl., at ¶ 17). The Committee unanimously concluded that, “3 – Most experienced, competent practitioners would have managed the case differently.” (Ames Decl., at ¶ 17; Ex. H).

On or about September 22, information concerning the September 11 incident was also provided to Dr. Daniel Sudilovsky, Chairman of Pathology and Laboratory Medicine. (Ames Decl., at ¶ 18; Sudilovsky Decl., at ¶ 3). In his capacity as Medical Director for Laboratories, all units of blood and other blood products for patient infusion are prepared, handled and administered under Dr. Sudilovsky’s license. (Ames Decl., at ¶ 18; Sudilovsky Decl., at ¶ 2). Accordingly, Dr. Sudilovsky is personally responsible for every person and process that affects any blood product anywhere in CMC and has absolute authority over the blood transfusion process. (Sudilovsky Decl., at ¶ 2). It is his duty to ensure safe handling and administration of blood products to ensure patient safety and maintain CMC’s, as well as his own accreditation. (*Id.*).

Dr. Sudilovsky was advised about the incident involving the two nurses who failed to follow established CMC protocol in administering a blood product transfusion. (Sudilovsky Decl., at ¶ 3). More specifically, he learned that the two nurses failed to perform the required two-nurse bedside verification process before performing the blood transfusion process. (Sudilovsky Decl., at ¶ 4). Based on the facts collected during the course of the investigation, on

September 26, Dr. Sudilovsky sent an email to Ms. Raupers in which he concluded that “these two individuals should not be in positions in which their duties or functions as nurses could again jeopardize patient safety in our system.” (Ames Decl., at ¶ 18; Sudilovsky Decl., at ¶ 5 & Ex.

A). He went on to state:

I can only conclude from these facts that the nurses in this case acted in a wantonly and willfully reckless manner by sidestepping the fail safes of our standard operating procedures and endangered this patient’s life in doing so. Not following protocol to positively identify the patient prior to transfusion by using stickers on a clipboard at the nursing station rather than the patients arm band at the bedside to identify the patient represents a clear near miss/or potential serious harm scenario. As experienced nurses, represents a particularly egregious infraction and I have little reason to believe that this would not be repeated at some point in the future or that this form of disregard for protocols will not be passed on to less experienced staff, if they are in positions to do so.

(Sudilovsky Decl., at ¶ 7 & Ex. A).

At no point did Ms. Ames or Ms. Raupers identify the two nurses involved in the September 11 incident, nor did Dr. Sudilovsky have any independent knowledge of the nurses involved in the September 11 incident. (Sudilovsky Decl., at ¶ 6). His evaluation of the situation was based solely on the facts and circumstances of the violation of procedure, and the grave threat posed by the reckless and purposeful failure of the nurses to follow necessary protocol. (Sudilovsky Decl., at ¶ 6).

Based on the investigation and the conclusions reached by both the Nursing Peer Review Committee and Dr. Sudilovsky, the decision was made to terminate Ms. Marshall and Ms. Lamb’s employment, as the nurses’ actions were reckless and posed a substantial and unjustifiable risk to the patient. (Ames Decl., at ¶ 25; Raupers Decl., at ¶ 5). Indeed, it would have been reckless of CMC to allow Ms. Marshall and Ms. Lamb to return to work. (Raupers Decl., at ¶ 5; Sudilovsky Decl., at ¶ 8).

**D. The New York State Education Department's Office of the Professions Investigation**

Because Ms. Marshall and Ms. Lamb's misconduct involved a knowing falsification of medical records and deliberate violation of established safety standards, CMC determined that this constituted "professional misconduct" as defined by the New York State Education Department's ("NYSED") Office of the Professions. (Raupers Decl., at ¶ 6). Consistent with CMC practices, on October 20, 2016, Ms. Raupers filed an incident report with the NYSED Office of the Professions regarding both nurses. (Raupers Decl., at ¶¶ 6-7). Such complaints of professional misconduct are independently investigated by the respective Regional Office of Professional Discipline. (Raupers Decl., at ¶ 8). In cases where the Regional Office finds "sufficient evidence" that misconduct has occurred, the case is referred to the Prosecutions Division of the Office of Professional Discipline. (Raupers Decl., at ¶ 9, Ex. A).

On February, 17, 2017, CMC received notice that the Regional Office had completed its investigation of Ms. Marshall's and Ms. Lamb's conduct. (Raupers Decl., at ¶ 10). The Regional Office, finding sufficient evidence of professional misconduct, referred both cases to the Prosecutions Division for further action. (Raupers Decl., at ¶ 10, Ex. B). Accordingly, Ms. Marshall and Ms. Lamb's licenses to practice nursing may be at risk due to the ongoing NYSED prosecution. (Raupers Decl., at ¶ 11).

**E. Ongoing Union Organizing Activities**

1199 SEIU United Healthcare Workers East ("SEIU" or the "Union") began an attempt to organize nurses at CMC in April 2015. (Declaration of Jeffrey Probert ("Probert Decl."), at ¶ 7, Exs. C & D). There are approximately 450 RNs working at CMC. (Declaration of Brian Forrest ("Forrest Decl."), at ¶ 7).

At no time since initial attempts to organize began has a petition for an election to certify SEIU as the employees' exclusive bargaining representative been filed with the NLRB. (Forrest Decl., at ¶ 8). Indeed, the only purported evidence of the number of authorization cards collected is set forth in a publicly available blog article posted on Truthsayers.org. (Probert Decl., at ¶ 5, Ex. C). In that article, entitled "Nurses Leaving Cayuga Medical Center in Mass Exodus," Ms. Marshall makes the claim that 175 CMC nurses had signed cards back in August 2015, but by October 2016, 25% of those nurses had left CMC. (Probert Decl., Ex. C). Additionally, Region Three's affidavits submitted in support of its Injunction Petition indicate that two of the primary union proponents, Erin Bell and Scott Marsland, left CMC in the Spring/early Summer of 2016. (Ex. G, at ¶ 4 & Ex. H, at ¶ 4 of Petition for Injunction under Section 10(j) under the National Labor Relations Act, as amended ("Petition for Injunction"), Dckt. No 1-2). One of these affidavits also indicated that there was "generally not much discussion of the Union in the Short Stay Surgical Unit since the campaign started" and there was no one in that unit who wore pro-union buttons since the campaign began. (Ex. G, at ¶ 3 of Petition for Injunction).

Upon reviewing the public Facebook posts concerning union meetings, it appears that one union meeting was held on or about July 28, 2016. Only one individual responded on the Facebook page that s/he was attending. (Probert Decl., at ¶ 4). According to one affidavit provided by Region Three, there were 20 attendees at a Union meeting after Ms. Marshall and Ms. Lamb were terminated. (Ex. G, at ¶ 6 of Petition for Injunction). It therefore appears that organizing activities may have increased since July 2016.

Further, a review of public Facebook posts from the publicly available group, "Unionize CMC RNs Now" shows that since October 2016 RNs have continued to regularly discuss terms and conditions of employment, including a recent incident where a nurse was terminated for

falsifying documents relating to a triage. (Probert Decl., at ¶ 8, Exs. D & E). In fact, Ms. Marshall regularly contributes to the Facebook discussions and her posts are regularly shared on the page. (Probert Decl., at ¶ 9, Ex. F).

Additionally, since Ms. Marshall's and Ms. Lamb's terminations in October 2016, employees have spoken freely to the local media about the organizing effort at CMC. For example, on or about October 24, 2016, employees, including two RNs, gave interviews to a local news reporter about terms and conditions of employment at CMC and the status of the union organizing campaign. (Probert Decl., at ¶ 6, Ex. C). This October 24 article included a picture of current RN Cheryl Durkee tabling in the CMC cafeteria in support of the union. (*Id.*). Indeed, Ms. Durkee is an active supporter of the union and it is CMC's understanding that she has taken on the role of union organizer. In mid-February 2017, she stated to her manager, Andrea Champion, Director of Emergency Services, that she was not only a union supporter, but a union organizer. (Declaration of Andrea Champion ("Champion Decl."), at ¶ 2).

Ongoing organizing activity is also evidenced by the fact that a number of employees have continued to show their support for the union by wearing union buttons and other paraphernalia in support of the Union. (Champion Decl., at ¶ 3).

#### **F. Distribution Policy Enforcement**

CMC has always maintained two separate types of bulletin boards throughout the medical center. Bulletin boards adjacent to the time clocks have always been exclusively reserved for official CMC business, including such items as statutory notices to employees, information about employee benefits, and memoranda from senior leadership on various topics (referred to as "official bulletin boards"). (Forrest Decl., at ¶ 2). Other bulletin boards located in break rooms and a public bulletin board near the cafeteria are open for employee use to post non-work related

material, such as advertisements for dancing lessons, used cars for sale, apartments for rent, etc. (Forrest Decl., at ¶ 3). Ms. Barr did remove one union posting from an official bulletin board adjacent to the time clock in the ICU. (Forrest Decl., at ¶ 4).

CMC does not allow non-work related materials to be posted on this particular bulletin board since it is one of the official bulletin boards reserved exclusively for CMC business. (Forrest Decl., at ¶ 5). CMC allows non-work related materials to be posted on the bulletin boards set aside for employee use, including in the ICU break room, where many union notices have been posted and been allowed to remain. (Forrest Decl., at ¶ 6).

### **ARGUMENT**

The Regional Director has failed to establish that an injunction under Section 10(j) is warranted. There is no merit to the allegation that Ms. Marshall's and Ms. Lamb's terminations violated the Act, and there is no evidence that the Union, the former employees or anyone else will suffer harm absent an injunction.

Injunctive relief under Section 10(j) is an "extraordinary remedy" to be used only where "the remedial purpose of the Act would be frustrated unless immediate action [is] taken." *McLeod v. General Elec. Co.*, 366 F.2d 847, 849 (2d Cir. 1966), *vacated as moot*, 385 U.S. 533 (1967). The "extraordinary" relief available under Section 10(j) is not intended to alter the basic framework of the Act, "which envisaged a system in which the Board would, in the first instance, consider and decide the issues arising under the Act and pending before it, subject to later review by the Courts of Appeals." *Silverman v. 40-41 Reality Assocs., Inc.*, 668 F.2d 678, 680 (2d Cir. 1982); *see also Kaynard v. Mego Corp.*, 633 F.2d 1026, 1034 (2d Cir. 1980).

The Second Circuit has instructed district courts to issue a Section 10(j) injunction only where two factors are present: "First, the court must find reasonable cause to believe that unfair

labor practices have been committed. Second, the court must find that the requested relief is just and proper.” *Hoffman v. Inn Credible Caterers, Ltd.*, 247 F.3d 360, 365 (2d Cir. 2001). That test requires that the Board “come forward with evidence sufficient to spell out a likelihood of violation.” *Danielson v. Joint Bd. of Coat, Suit and Allied Garment Workers’ Union*, 494 F.2d 1230, 1243 (2d Cir. 1974); *Paulsen v. Renaissance Equity Holdings, LLC*, 849 F. Supp. 2d 335, 353 (E.D.N.Y. 2012).

Region Three fails both prongs of this test. With regard to the first prong, Region Three submits no evidence at this time<sup>1</sup> to support its claim. As to the second prong, Region Three’s petition does not meet the “just and proper” test, which requires it establish that an injunction is necessary to prevent irreparable harm. *See Inn Credible Caterers*, 247 F.3d at 368; *see also Ahearn v. House of the Good Samaritan*, 884 F. Supp. 654, 661 (N.D.N.Y. 1995) *citing Kaynard v. Mego Corp.*, 633 F.2d 1026, 1033 (2d Cir. 1980); *Blyer v. Jung Sun Laundry Group Corp.*, No. 10-cv-2975, 2010 WL 4722286, at \*7 (E.D.N.Y. Nov. 15, 2010).

#### **A. THE NURSE’S TERMINATIONS DID NOT VIOLATE THE NLRA**

As noted, Region Three does not submit any evidence in support of its argument that reasonable cause exists to believe that Respondent violated Section 8(a)(1) and 8(a)(3) of the Act by suspending and terminating Ms. Marshall and Ms. Lamb.

In contrast, CMC submits sufficient evidence to show that Ms. Marshall and Ms. Lamb were terminated for deliberately and knowingly violating a critical policy and admittedly falsifying medical records to cover that violation. Ms. Lamb never set foot in the room despite certifying that she had. Ms. Marshall lied to the nervous patient questioning her about CMCs

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<sup>1</sup> Region Three requests that this Court make its determination on reasonable cause after the administrative hearing is complete and the parties have had an opportunity to address the administrative record through briefings. Therefore, Region Three has submitted no evidence on this prong at this time.

policy, and caused that patient further concern by telling her that her previous nurses must have been inexperienced. When Ms. Marshall was questioned about the incident, instead of showing any sort of remorse or acknowledgement that what she did was wrong, insisted that the verification policy was not necessary so she should not have to follow it.

Accordingly, Ms. Lamb and Ms. Marshall were both appropriately terminated for their flagrant misconduct and disregard for patient safety. Indeed, both nurses are currently being prosecuted by the NYSED for professional misconduct in connection with the September 11 incident, undermining Region Three's assertion that such employees were terminated for union activity. CMC regularly terminates employees for falsifying medical records. (See, e.g., Union's Facebook postings regarding nurse terminated for falsifying triage records; Probert Decl., at Exs. E & F; Ames Decl., at ¶ 22).

Contrary to Region Three's suggestion, in considering whether to grant a Section 10(j) injunction, a district court does not serve as a mere rubber stamp for the Regional Director's allegation that an unfair labor practice has occurred. Rather, in considering the Board's allegations against an employer, the Court gives only "*appropriate* deference" to the factual and legal theories of the Board. *Silverman v. Major League Baseball Player Relations Comm., Inc.*, 67 F.3d 1054, 1059 (2d Cir. 1995) (emphasis added); *see also 40-41 Realty Assocs., Inc.*, 668 F.2d at 681 ("*some* degree of deference is warranted when the Regional Director seeks an injunction under section[] 10(j)") (emphasis added). However, no deference is appropriate where the Board's "legal or factual theories are fatally flawed." *J.R.L. Food Corp.*, 196 F.3d at 335; *see also Inn Credible Caterers*, 247 F.3d at 365; *Mego Corp.*, 633 F.2d at 1033.

Here, Region Three does not submit any evidence in support of its assertions that reasonable cause exists that an unfair labor practice occurred. Instead, it relies solely on

conclusory statements in its Memorandum of Law that documentary evidence exists to support its assertions that reasonable cause exists to believe an unfair labor practice occurred. Therefore, Region Three provides no basis for this Court to evaluate whether the Board's legal or factual theories are fatally flawed. Under the evidence submitted by CMC, there is clearly no reasonable cause to believe an unfair labor practice has occurred, and CMC contends that the administrative record, once fully developed, will substantiate that these terminations did not violate the Act.

**B. INJUNCTIVE RELIEF WOULD NOT BE “JUST AND PROPER” IN THIS CASE**

Even if the Board were to establish reasonable cause, which it cannot, Region Three's request for an injunction should be denied because it cannot demonstrate the requested injunction is “just and proper” under the circumstances presented here. The extraordinary remedy sought is only “just and proper” where there has been a showing that it is necessary to preserve the status quo or prevent irreparable harm. *Ahearn* 884 F. Supp. 654 at 661 *citing Kaynard*, at 1033. Thus, to determine whether an injunction is proper, the Court must apply the same general equitable principles that ordinarily apply in determining the propriety of injunctive relief, including irreparable harm, balance of the equities, and the public interest. *See Ahearn*, 884 F. Supp. at 661-63.

Applying these principles, injunctive relief cannot be just and proper in this case because there is no threat of remedial failure, and the balance of equities and the public interest weigh strongly against injunctive relief. Most importantly, the interest in protecting the health, safety, and welfare of CMC patients far outweighs a highly speculative belief that reinstating Ms. Marshall and Ms. Lamb may reinvigorate a Union campaign that appears to have dissipated long before the two nurses were terminated.

As noted above, Region Three essentially argues that CMC, and this Court, must ignore, among other things, a deliberate and knowing violation of the most fundamental and critical safeguard in the blood transfusion process, falsification of medical records, the NYSED finding sufficient evidence of professional misconduct, and the fact that reinstatement will send a message to all other employees that CMC cannot enforce or expect compliance with its most critical policies.

The primary reason Region Three claims these employees must be reinstated is because there is no longer a union organizer at CMC and employees may be intimidated from showing support for the Union. Again putting aside Region Three's attempt to place collective bargaining rights over the risk to human life, the evidence presented does not support Region Three's claimed need for injunctive relief. The evidence shows, for example, that current Emergency Department Nurse Cheryl Durkee is a Union organizer and recently informed her manager of this fact. A newspaper article that post-dates Ms. Marshall's and Ms. Lamb's terminations pictures Ms. Durkee tabling for the Union. In that article, Ms. Durkee also discusses terms and conditions of employment as well as the need for a union. Another nurse, David Kraskow, is quoted in the same article advocating for unionization. Moreover, several nurses, including Ms. Durkee, continue to regularly wear SEIU buttons at CMC. Employees, and former employee Ms. Marshall, also continue to publicly advocate unionization and discuss terms and conditions of employment on the Facebook page, Unionize CMC RNs.

When weighing the potential risks of reinstating two nurses who are now under prosecution for professional misconduct, against the speculative theory that their reinstatement could potentially revitalize a fading union campaign that never obtained popular support, patient safety must prevail.

## **1. There Will Be No Irreparable Harm if these Employees Are Reinstated**

There will be no irreparable harm if these employees are not reinstated. Irreparable harm is shown only where a failure to provide relief will “threaten to render the Board’s processes totally ineffective by precluding a meaningful final remedy.” *Blyer v. P&W Elec., Inc.*, 141 F. Supp. 2d 326, 328 (E.D.N.Y. 2001), quoting *Kaynard v. Mego Corp.*, 633 F.2d 1026, 1034 (2d Cir. 1980). There is nothing extraordinary about this case that would render the Board’s processes “totally ineffective.” This is an entirely routine case alleging that employees were discharged in violation of the Act; the appropriate remedy for the alleged violation — reinstatement with backpay — would leave the employees in the exact same position without the requested injunction. See *Warnervision Entm’t Inc. v. Empire of Carolina, Inc.*, 101 F.3d 259, 261 (2d Cir. 1996) (“The purpose of a preliminary injunction is not to give the plaintiff the ultimate relief it seeks.”). That remedy is certainly not “totally ineffective” and thus does not warrant an injunction. See *P&W Elec., Inc.*, 141 F. Supp. 2d at 328.

Petitioner’s argument that reinstatement is appropriate because the nurses may have moved to other jobs by the time the administrative process is complete is without merit. “Section 10(j) should be applied in the public interest and not in vindication of purely private rights.” *Paulsen*, 2016 at \*41 citing *Seeler v. Trading Port, Inc.*, 517 F.2d 33, 38 (2d Cir. 1975). There is therefore no basis for injunctive relief.

## **2. The Public Interest Demands Denial Of The Petition**

An order reinstating these nurses — without *any* unfair labor practice finding — would undermine CMC’s policies and public trust in the services provided by CMC.

The two-nurse bedside verification process is the final and most critical safeguard against potentially fatal error. Not only did the nurses fail to follow procedure, but Ms. Marshall would not even acknowledge the procedure when confronted by the concerned patient. When the

patient asked Ms. Marshall why she was not performing the blood transfusion in the same fashion the numerous previous nurses who had performed transfusions on her, Ms. Marshall disregarded the patient's concern, claiming the other nurses must have been inexperienced. Ms. Marshall later claimed that the policy should not apply to her because she was a good multitasker. Similarly unacceptable, Ms. Lamb acknowledged on the patient's transfusion card that the safety procedures were followed, even though she never set foot in the patient's room during the transfusion.

Simply put, failing to terminate these two employees would have been reckless and endangered the lives of CMC patients. Interim reinstatement of these employees would be the same. Interim reinstatement would senselessly put patients at risk, as the nurses have demonstrated a clear willingness to disregard CMC's established safety protocol. Where a hospital/nursing home employee poses an ongoing risk of patient harm, the court properly found in *Lightner v. 1621 Route 22 W. Operating Co., LLC*, Civ. No. 11-2002, 2012 U.S. Dist LEXIS 52896, \*153-55 (D.N.J. Apr. 16, 2012), that "the impact reinstating [the former employee's] employment would have on [the employer] and on its patients far outweighs the incremental public interest served by further safeguarding the collective bargaining process."

In reaching its decision, the court in *Lightner* highlighted the obvious: a nursing home is not a factory, mine, or assembly plant. *Id.* at 147. CMC respectfully submits that the present injunction motion should be evaluated similarly, recognizing that CMC is a place:

where human ailments are treated, where patients and relatives alike often are under emotional strain and worry, where pleasing and comforting patients are principal facets of the day's activity and where the patient and his family—irrespective of whether that patient and that family are labor or management oriented—need a restful, uncluttered relaxing and helpful atmosphere, rather than one remindful of the tensions of the marketplace in addition to the tensions of the sick bed.

*Id.* at 147 fn. 36.

In the instant proceeding, Ms. Marshall and Ms. Lamb deliberately and knowingly violated a policy, falsified medical records, and Ms. Marshall directly lied to a nervous patient about CMC policy and caused further concern by telling her that her other nurses must have been inexperienced ones. She also insisted during the investigation that the policy itself isn't necessary so she shouldn't have to follow it. Putting either of these individuals back in a position where they can harm a patient, at the same time they are under prosecution for professional misconduct by the NYSED, would create unnecessary risk to CMC's patients.

Reinstatement would also confirm to all other employees that they can ignore vital checks and procedures that could save a patient's life. This sort of dangerous precedent cannot be supported and would go directly against the public interest.

### **3. There is No Compelling Necessity to Preserve the Status Quo**

There is no need for the Regional Director to have prospective relief against CMC in order to preserve the status quo while the ALJ continues to hear the claims. The Regional Director has suggested that this is a "nip in the bud" case, in which an allegedly unlawful discharge, if not immediately remedied, will frustrate an organizing campaign that is in progress. But this is not such a case.

The Union has sought to organize RNs at CMC dating back to April 2015. The unit sought to be organized is approximately 450 employees. At no time since the organizing drive began has a petition for an election to certify SEIU as the employees' exclusive bargaining representative been filed with the NLRB. Indeed, the only statement regarding the number of authorization cards ever signed is set forth in a publicly available blog article posted on

Truthsayers.org. In this article, Ms. Marshall claims that 175 CMC nurses had signed cards by Autumn 2015. She then claims that by October 2016, 25% of those nurses had left CMC.

Additionally, Region Three's affidavits highlight that two major proponents of the Union, Scott Marsland and Erin Bell, voluntarily left CMC in Spring/Summer of 2016. Thus, there are numerous reasons why Union organizing campaign was dwindling before the termination of Ms. Marshall and Ms. Lamb. From the evidence available via Facebook, attendance at union meetings may have actually increased after the termination of Ms. Marshall and Ms. Lamb.

In sum, SEIU has been attempting unsuccessfully to organize this group of employees since early 2015. They have lost at least 25% of their initial supporters, two primary organizers left CMC in spring/summer 2016, and attendance at Union meetings was poor prior to the terminations. Under these circumstances, collective bargaining rights will not be undermined by denying interim reinstatement. *Paulsen v. CSC Holdings, LLC*, 2016 U.S. Dist. LEXIS 30259, \*40-41 (E.D.N.Y. Mar. 8, 2016) (finding failure to reinstate employee will not undermine collective bargaining rights where interest in the Union was low).

Further, despite Region Three's contention that there are no union organizers left and individuals are intimidated to talk about the union in fear of being disciplined, the evidence does not support this claim. Employees have spoken freely to the local media about the organizing effort at CMC and one nurse, Ms. Durkee, indicated to her manager that she is an organizer. Ongoing organizing activity is also evidenced by the fact that a number of employees have continued to show their support of the union by wearing union buttons and other paraphernalia in support of the union. Also, a review of public Facebook posts on Unionizing CMC RNs shows that since October 2016 RNs have continued to regularly and openly discuss terms and

conditions of employment, including a recent incident where a nurse was terminated for falsifying documents relating to a triage.

Ms. Lamb and Ms. Marshall are free to actively support the Union through Facebook, and Ms. Marshall's postings are frequently shared on the Unionizing CMC RNs Facebook page. Significantly, the court in *Paulsen* found that delay will not undermine collective bargaining rights where "Evidence has been presented that [the terminated employee] continues to actively support the Union by emailing her former co-workers. *Id.* at 41.

The evidence shows that interest in the Union was dwindling prior to the termination of Ms. Marshall and Ms. Lamb, and if anything, it suggests that there may now be an increase in attendance at Union meetings. Ms. Durkee has stepped in as union organizer, employees speak freely with the press about the unionization effort, employees continue to wear SEIU or "organize" buttons, and former employees, Ms. Marshall and Ms. Lamb, are free to express their support for unionization over the internet and through the media. Under these circumstances, denying Region Three's request for an injunction will not undermine collective bargaining rights.

#### **4. Region Three's Delay in Seeking the Injunction Shows it is Not Necessary**

Finally, Region Three's contention that immediate reinstatement is necessary to avoid remedial failure is belied by its own delay in initiating this proceeding. Section 10(j) is to be reserved for circumstances requiring "immediate" relief. *McLeod v. General Elec. Co.*, 366 F.2d 847, 849 (2d Cir. 1966), *vacated as moot*, 385 U.S. 533 (1967). Region Three's delay demonstrates that this is not such a case.

The Regional Director refrained from initiating this proceeding until more than four months after the employees' terminations and nearly three months after it issued its Complaint. This delay shows that there is no urgency to this case such that would require this Court to

intervene in and interfere with the Board's usual processes. *See Seeler v. H.G. Page & Sons, Inc.*, 540 F. Supp. 77, 79 (S.D.N.Y. 1982) (where Board delayed in seeking injunction for four months, "[the 10(j)] remedy does not apply where the Board itself does not treat the ongoing violations with urgency. . . . [10(j) was] not intend[ed] to countenance undue delay in requesting interim injunctive relief. The Board's inaction in this case is the most compelling evidence against the need for intervention by this court"); *Silverman v. Local 3 IBEW*, 634 F. Supp. 671, 673 (S.D.N.Y. 1986) (delay of three months in seeking 10(j) injunction "seriously, indeed fatally, undermines the Board's position that an injunction is necessary to protect against harm to the public"); *Moore-Duncan v. Traction Wholesale Ctr. Co.*, No. 97-6544, 1997 WL 792909, at \*3 (E.D. Pa. Dec. 19, 1997) (petition denied, noting that the six-month delay in seeking the petition "raises some concern as to whether the injunction is necessary").

The procedural posture and facts in *Paulsen* are instructive here. In that case, a charge was filed on June 18, 2015, a complaint issued on August 24, 2015 and the Administrative Law Judge took testimony on various dates between September 28, 2015 and October 30, 2015. The NLRB then filed its petition while additional hearing days were remaining. *Paulsen*, at \*38-39. The Board also made the identical argument it makes here that the employer fired the main union proponent, and therefore immediate reinstatement was required. *Id.* at 38-39. In responding to the Board's contention and ultimately denying injunctive relief for this and other reasons, the court stated:

Given the Petitioner's Argument that "Perry was the face of the Union campaign in Jericho and as a result of her termination, 'everything was shut down,'" one would expect that an application for §10(j) relief would have been made on a more timely basis.

*Id.* Similarly here, waiting to file the injunction papers until four months later weighs against the argument that immediate relief is necessary. Further, the unfair labor practice charge is currently

being tried, and it is reasonable to expect the trial to be completed soon and a decision issued. There has not been a sufficient showing of irreparable harm to justify a court in interfering at this stage and in effect doing the Board's work for it. *See McLeod v. Art Steel Co., Inc.*, No. 71-cv-2571, 1971 WL 783, at \*1 (S.D.N.Y. 1986) (Holding it would be unjustified for a court to interfere and "in effect do the Board's work for it" after a three month delay in seeking an injunction and the alleged violation was tried for over a month).

### **CONCLUSION**

For the foregoing reasons, CMC respectfully requests that the Court deny the petition in its entirety.

Dated: March 3, 2017

Respectfully Submitted,

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